Coding & Billing Guidance Document, Version 12
Webinar Q & A
April 17 & 18, 2019

Q-: For 2 step PPD for Admission to Skilled Nursing Facility, is it ok to add 2nd dx of Z02.2?

A- Yes, as long as the provider includes on encounter.

Q- How do you bill for Nexplanon and post-partum on same day? We only get paid for Nexplanon and not post-partum visit. Can you please help?

A- According to the ACOG LARC Quick Coding Guide (2018 update) when using Preventive Medicine Codes you should bill as follows:

11981	-FP	Z30.17
9938X/9939x	-FP -25	Z01.41- (1 or 9)/Z30.017
J7307	-FP	Z30.017

- When using global post-partum code 59430:
  Nexplanon® implant (from page 66 CBGD)
  - Return within 60 days of delivery for postpartum visit in Family Planning Clinic
    - LHD uses CPT code 59430 (package code) and
    - Incentive code S0281 (if LHD is a PMH) and
    - Diagnostic ICD-10 code, Z39.2
      - Insertion CPT code 11981 FP and
      - Diagnostic ICD-10 code, Z30.018 and
      - Contraception HCPCS code:
        - Nexplanon® J7307 FP UD
  - Billing guidance
  - - 25 Modifier cannot be used with the insertion CPT code 58300/11981 when CPT code 59430 (package code is being used)
  - The FP Modifier must be used on the IUD insertion code 58300/11981.
  - The FP and UD modifiers must be used when billing the IUD HCPCS code or anytime the contraceptive method was purchased utilizing 340B stock
  - 340B stock may only be used in the LHD Family Planning Clinic, not the Maternal Health Clinic
  - The provider must include the appropriate diagnostic code for the contraceptive method and counseling

REMINDER: You must include an FP diagnosis (Z30.xx) with all birth control related claims. If you continue to have trouble getting paid properly, please submit a ticket to NC Tracks or send ENCRYPTED TCNs to shnaka.clark@dhhs.nc.gov. PLEASE BE SURE TO ENCRYPT THE EMAIL MESSAGE.

Q- Regarding slide 30, Plan B is not payable to HD's from Medicaid?

A- That is correct. We apologize that the initial information we received was incorrect.

There currently is no code with which to bill Medicaid for ECP. We suggested agencies use those two codes to bill private insurance or just to track the service.

- If the client has Medicaid or insurance, they may be given a script to take to the pharmacy to be filled. If there are barriers to the client using their Medicaid or Insurance, 340B stock from the HD may be used, but there is no mechanism for the LHD to bill Medicaid for ECP at this time.
- ~~If the agency dispenses, and they have purchased using 340B they may bill Medicaid their acquisition cost (with HCPCS code S5001 or S5001) and append the UD modifier and NDC.~~
- If the client does not have Medicaid…agency can set fees using ~~the HCPCS codes above~~ HCPCS code S5001 or S5001

Q- What is considered a barrier with regard to the ECP?

A- The client may be confidential and would not want to present to a pharmacy for ECP. In that case the health department would dispense from their stock.

Q- Going back to the maternal health slide, are you stating that the confirmation of pregnancy 99211 should be included in the global package.

A- Yes, unless the client is seen for less than 4 visits.

The pregnancy test visit may be included in the MH package billing or be billed as a 99211 if the client is seen for only one or two additional visits before she is transferred out or her Presumptive Eligibility (PE) expires, provided coverage is in force (preexisting Medicaid or PE on the date of the PT visit).

If the agency has collected for a pregnancy test visit as a flat rate from the client and you plan to bill Medicaid for the PT visit, you must return the money paid for the PT to the client first. Please remember no "flat fee" services may be billed through FP or MH. If you bill the service in FP or MH then it must slide accordingly.

All services for a Presumptively Eligible client who is seen for four or more visits (perhaps a PT, a nurse visit, and two provider visits) should be billed with a package code (59425, 4-6 visits).

Q- We cannot bill admin fee for a free vaccine.

A- An administration fee is allowed when providing state-supplied vaccine. It may be billed to Medicaid, insurance or self-pay as long as you follow the eligibility guidelines for VFC. Please refer to the Coding & Billing Guidance Document, Immunization Section which begins on page 33.

Q- We had billed individual visits through MH and had received payment, then we found out that we had to do package billing. We reimbursed Medicaid by voiding those claims. Once all money was recouped by Medicaid we resubmitted our package billing and never received payment, it was denied. Any idea of why we wouldn't have got paid. The service was from a prior year when we had caught the mistake.

A- You will need to submit several TCN's as examples of this to Shnaka Clark at shnaka.clark@dhhs.nc.gov. PLEASE BE SURE TO ENCRYPT THE EMAIL MESSAGE.

Q- Does Medicaid cover Medical Nutrition Therapy (MNT) services for recipient? Is it for Pregnant women or children only?

A- Yes. Medicaid will pay for MNT for children (through age 20) and Pregnant/Postpartum women. Please refer to the Coding & Billing Guidance Document, V12 beginning on page 121 for additional information.

Q- Just to be clear the TJ is no longer required when billing North Carolina Health Choice (NCHC)? Just FP modifier?

A- When billing Family Planning services for a NCHC covered individual, you do not use the TJ modifier, just the FP modifier in order to be paid for the correct amount.
Non-Family Planning services still require the use of the TJ modifier to identify a NCHC covered individual.

Q- if a patient just wants to have a TB skin test in which program should be register the test is for work or for school?

A- As stated in the Coding & Billing Guidance Document, V12, page 50:
If the only service that a client comes in for is a skin test due to employment or school, then the service should go under the TB program.